

Section I: Looking Back, Looking Forward

Chapter 1

SAMHSA's Center for Mental Health Services: A Decade of Achievement, 1992–2002

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Introduction

Public Law 102–321 established the Substance Abuse and Mental Health Services Administration (SAMHSA) in October 1992. Its statutory mission is to strengthen the capacity of the Nation's health care system to provide prevention, diagnosis, and treatment services for people at risk for or experiencing mental or substance use disorders. SAMHSA's Center for Mental Health Services (CMHS) is charged with improving the quality of and access to mental health services, especially for underserved populations and people at greatest risk—adults with serious mental illnesses and children and adolescents with serious emotional disturbances.

What follows is an overview of CMHS's efforts to improve mental health services over the decade since the Agency itself was created, the period between 1992 and 2002. By applying the public health model to mental health, CMHS has developed innovative programs that address the causes of mental illnesses and emotional disturbance, and that emphasize early intervention and prevention of illness. Implementation of the public health approach is traced through a description of the programs undertaken by CMHS. Describing all of the

important activities that have helped usher in a new era for mental health services, however, is beyond the scope of this endeavor.

Evolving Awareness

CMHS's first decade saw an explosion in awareness of the need for mental health services. The last half of the decade helped America begin to recognize mental illnesses as the chronic, treatable illnesses they are—illnesses from which people can and do recover:

- In 1999, the Surgeon General of the United States issued *Mental Health: A Report of the Surgeon General* (U.S. Department of Health and Human Services [HHS], 1999), which engaged the American public in a discussion about the importance of mental health. This report included a key statement and recommendation: "Mental health is fundamental to well being; America must make strong mental health a public issue—and mental illness not a secret to be hidden in the family closet."

- That same year, a White House Conference on Mental Health confronted head-on the issue of discrimination and the stigma of mental illness.
- In 2000, support for State systems of community-based mental health care received a boost with a \$64,000,000 increase in the CMHS Block Grant, followed by an additional \$57,000,000 increase in FY 2001. These increases reflected growing awareness of the unmet needs among adults with serious mental illness and children and adolescents with serious emotional disturbances.
- In 2001, the National Strategy for Suicide Prevention (HHS, 2001a) set a course for suicide prevention throughout every community in the country, which led to Federal support for creation of a national suicide prevention resource center.
- In 2002, President Bush stated strong support for mental health insurance parity. The President deplored the fate of people with mental illnesses who “fall through the cracks.” He also signed Executive Order 13263 creating the *New Freedom Commission on Mental Health* and charged it with issuing a report describing barriers to care within the mental health system, providing examples of successful community-based care models, and suggesting ways to fix the problems (Bush, 2002).

Legislative Authority

In 1992, mental health service delivery was evolving from provider-centered to community- and consumer-centered systems of care. The need for vigorous Federal leadership to develop that new direction in mental health services found its way into law. Public Law 102–321 restructured the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA) and created SAMHSA, of which CMHS is a part. Congress recognized the need for a separate focus on systems of care to assist children and adolescents with severe emotional disturbances and to help individuals experiencing homelessness.

The new law contained provisions focused on the “prevention of mental illness and promotion of mental health,” the protection of the “legal rights of persons with mental illness,” the assurance of

increasingly “widespread dissemination” of mental health information, and the establishment of “comprehensive community health services for children with serious emotional disturbances.”

Public Health Approach

By 1981, when ADAMHA was created, America had come a long way in its efforts to combine drug and mental health research, and service-related programs. In the decade that led to the creation of SAMHSA, Congress began authorizing additional service programs for special populations. During that decade, provision of mental health services in community settings rather than in institutions continued to become more common (Witkin et al., 1998). Community-based care was taking hold, literally one State at a time.

While the 20th century medical model focused on curing sickness or treating injuries *after* they occurred, the 21st century ushered in a public health model for mental health. The public health model considers factors related not only to the individual but also to family, peers, education, and community—environmental factors, not just individual pathology. The model demonstrates that many mental disorders can be ameliorated by early intervention and that some can even be prevented.

At SAMHSA, CMHS focused on developing community-based programs and activities to implement the public health model. These activities included consumer-oriented and recovery-oriented programs, efforts to improve the mental health of children and families, measurement of service outcomes, and implementation of evidence-based practices.

Investing in Community-Based Programs

In 1993, CMHS had a budget of nearly \$385 million. The Community Mental Health Services Block Grant received almost 72 percent of this funding. The 1981 Block Grant legislation had combined the Mental Health and Substance Abuse Block Grants. The 1992 legislation, however, separated the two, with Mental Health Block Grant funding available to support State provision of comprehensive community mental health services to adults with serious mental illnesses and children and adolescents with serious emotional disturbances. An additional 14 percent of CMHS funds supported

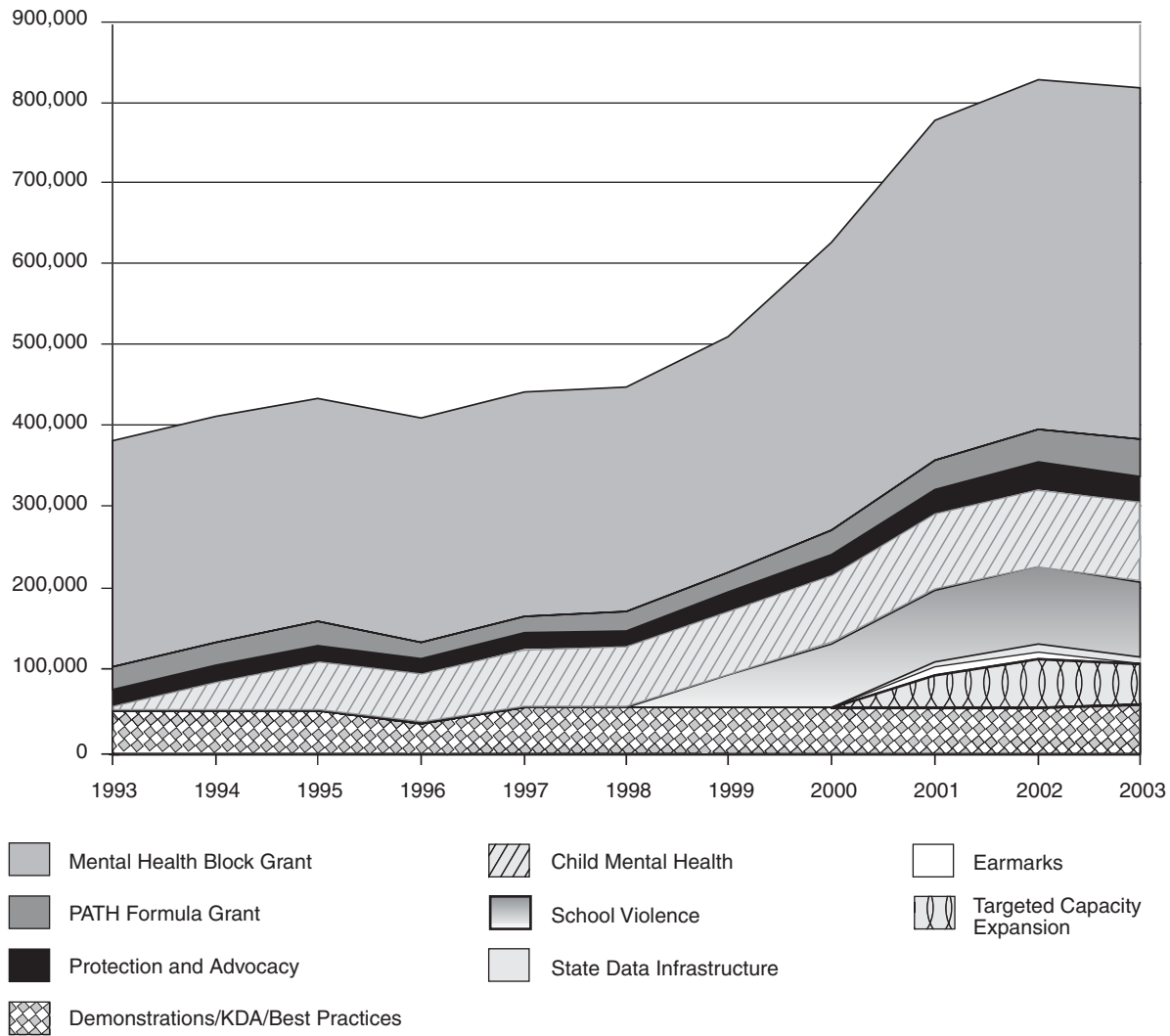


Figure 1. History of Center for Mental Health Services Funding.

demonstration programs on community support for adults with serious mental illness (including those who were homeless) and to programs of clinical training focusing on mental health for underserved populations and on HIV/AIDS—all areas emphasized during the congressional discussion that led to the creation of SAMHSA. Eight percent of the 1993 budget was allocated to the Projects for Assistance in Transition from Homelessness (PATH) program, nearly six percent to the Protection and Advocacy Program, and a little less than one percent to the newly created Comprehensive Community Mental Health Services for Children and Their Families Program.

Throughout the decade 1992–2002, CMHS remained committed to these programs. Halfway through the decade, the 1998 budget for CMHS was

\$451 million. The PATH and Protection and Advocacy programs each received approximately five percent of the CMHS budget, and the Children’s Mental Health Program, 16 percent. Congress level-funded the Mental Health Block Grant so that, in 1998, it represented 61 percent of the CMHS budget; while demonstration programs represented 12 percent.

For 2003, the total CMHS budget estimate was \$832 million, almost double the CMHS budget just five years earlier. The PATH program represents nearly six percent and Protection and Advocacy Program, approximately four percent. The Children’s Mental Health Program comprised 12 percent of the total and the Mental Health Block Grant, 52 percent. Programs of Regional and National Significance, which replaced demonstration projects with

SAMHSA's 2000 reauthorization (H.R. 4365, Section 3201), represent 26 percent of the estimated 2003 budget.

Over the decade, the original CMHS programs have been broadened by fostering the public health emphasis on prevention and early intervention and by building a network of community supports for individuals with mental illnesses. Gradually, CMHS has woven individual programs and services into an agenda that addresses emerging needs, from school-based prevention for troubled young people to jail diversion and expanded community treatment for adults focused on recovery. This work has helped establish the groundwork for the transformation of the U.S. mental health care system, as called for by the President's New Freedom Commission on Mental Health.

Developing Systems of Care

In 1993, the CMHS Child, Adolescent, and Family Services Program focused national attention on coordinated systems of care for young people with serious emotional disturbances by providing Federal dollars to help build the infrastructure needed to deliver these services. Armed with a \$5 million appropriation, CMHS began to build partnerships across local public and private agencies, with the goal of integrating the services children with severe emotional disturbances needed into a single plan, with the family leading the team.

Through 1998, this program had served more than 40,000 children and adolescents with serious emotional disturbances and their families in 67 sites spanning 44 States. The most recent data show that, as a result of improved outreach, the percentage of children in the program referred from courts and correctional institutions increased to 21 percent and from parents to 20 percent. After two years of program services, 42 percent of children showed a significant reduction in severe behavioral and emotional problems. The percentage of children with scores of 40 and below on the Child and Adolescent Functional Assessment Scale (CAFAS) more than doubled, indicating that these children were no longer considered clinically impaired in their social functioning (CMHS/SAMHSA, 1999).

By 2002, the CMHS appropriation for children's mental health was nearly \$100 million. The Children's Program gave impetus to a number of other programs that have helped to create the service environment needed to implement successful sys-

tems of care. For instance, the Health Resources and Services Administration's Maternal and Child Health Bureau adopted the system-of-care approach for children with special health care needs.

In an equally successful implementation of Congress's goal 10 years ago, CMHS used the initial \$29 million funding for PATH to develop comprehensive, community-based outreach services to help people who were both homeless and experiencing mental illness stabilize their lives. By 2003, PATH was funded at \$39 million. Between 1992 and 2002, nearly 400 local organizations used PATH's flexible funding stream to fill critical gaps in community services, such as outreach, job training, screening and diagnosis, and treatment services.

In 1993, CMHS funded a five-year, nine-State demonstration program to integrate services for homeless individuals with mental illness. The Access to Community Care and Effective Services and Supports (ACCESS) program was an interdepartmental effort undertaken with other Department of Health and Human Services agencies, as well as with the Departments of Labor, Education, Veterans Affairs, Agriculture, and Housing and Urban Development. Although the evaluation did not find the hypothesized connection between improved systems integration and overall client outcomes, a positive association was observed between improved systems integration and housing outcomes. ACCESS enhanced services for more than 7,000 persons with a serious mental illness who also were experiencing chronic homelessness (SAMHSA, 2001).

In 1996, CMHS's focus on long-term demonstration programs shifted to a new Knowledge Development and Application (KDA) approach. The KDA model promoted a two-part approach to address regional and national mental health issues. Knowledge development provided a framework to identify and apply best practices in community-based mental health services. Over the next few years, CMHS initiated KDA programs to assess new approaches, such as the effectiveness of managed care models in providing mental health services, treatment interventions for persons with co-occurring mental and substance use disorders, and methods to divert incarcerated adults with serious mental illness into effective treatment.

In 1997, CMHS introduced the KDA Community Action Grant program to help communities implement exemplary mental health service delivery practices. Community Action Grants build consensus among local stakeholders that the use of evidence-based mental health service practices will

help improve the quality of care. In a subsequent phase, barriers to change are confronted and the practice is implemented.

Results for Consumers

In 1996, CMHS established the Knowledge Exchange Network (KEN), since renamed SAMHSA's National Mental Health Information Center (NMHIC). Public Law 102-321 mandated that CMHS create a clearinghouse "to assure widespread dissemination of [mental health] information...applicable to improving the delivery of services" (1992). KEN, and now NMHIC, fulfills the dissemination functions of a clearinghouse by providing access to a broad range of information and educating policymakers.

CMHS demonstrated its commitment to consumer empowerment by specifically promoting a public mental health agenda that made consumers active participants in preventing and treating illness. In 1995, the first consumer affairs specialist was hired. By 2002, five full-time staff in the Office of Consumer Affairs supported consumer participation in developing the national agenda for mental health services.

A major goal of CMHS has been to address the damaging impact that discrimination and stigma continue to have on the lives of people with mental illnesses. CMHS has developed and widely disseminated anti-stigma materials, has sponsored a national symposium to identify promising efforts to counter discrimination and stigma, and has established the ADS (Anti-Discrimination and -Stigma) Resource Center to act as a clearinghouse for such information.

CMHS has promoted recovery by fostering the growing understanding that people with mental disorders can and do recover with the right community support and rehabilitation services. As part of this focus, CMHS implemented the Employment Intervention Demonstration Program, designed to evaluate different models of employment support for adults with serious mental illness, and convened a National Summit on Mental Health in the Workplace to improve integration of people with mental disabilities into meaningful employment. Approximately 85 percent of people with serious mental illnesses remain unemployed, but targeted efforts show promise for the future.

Prevention and Early Intervention

The public health approach has continued to unfold as science breaks new ground in prevention of mental and behavioral disorders. New knowledge has revealed the powerful role that developmental theory must play in mental health efforts (Institute of Medicine, 1994). As a result, CMHS has worked to move prevention to the forefront of the national mental health agenda. The Center's work on resilience has examined the strengths-based approach to child and adult development, and to prevention and treatment services. In addition, this work has provided a background for ongoing projects to identify and promote indigenous models of resilience among African Americans, American Indians and Alaska Natives, Asian Americans and Pacific Islanders, and Hispanic Americans.

A working paper on resilience for policymakers and the public, titled *Resilience: Status of Research and Research-Based Programs* (Davis, 1999), provided the foundation for the CMHS Violence Prevention Initiative, launched in 1999 to prevent risky behaviors and promote emotional strength in adolescence. Two years after the Violence Prevention Initiative was introduced, CMHS became instrumental in preparation of *Youth Violence: A Report of the Surgeon General* (HHS, 2001b), which presented intervention strategies from the research literature.

A key activity for CMHS has been the development of partnerships with other agencies and departments. It is clear that mental health services are part of a larger picture that can include the criminal justice system, juvenile justice, education, substance abuse, housing, employment, and the spectrum of social and health agencies. The Center experimented with combining funding streams among agencies and created a legacy of successful partnerships. A key example is the Safe Schools/Healthy Students program, which, for the first time without any congressional mandate, brought together three Federal departments—Education, Justice, and Health and Human Services—in a comprehensive approach to improve school and community mental health prevention and treatment services together with school safety.

Programs for older adults also emphasized early interventions. SAMHSA initiated an innovative project with the Health Resources and Services Administration, the Department of Veterans Affairs, and the Centers for Medicaid and Medicare Services to reach older adults with mental disorders through the primary care system. (It is well known that older adults are more likely to seek and receive

mental health and substance abuse services from their primary care provider than from specialty mental health or substance abuse services providers.) This multisite study compared the effectiveness of different service delivery models, such as services integrated within the primary care setting or referrals to specialty settings.

In other activities, the Center commissioned reviews of preventive practices and developed a curriculum to train mental health professionals to deliver prevention services. CMHS is strengthening the evidence base of preventive interventions through programs that measure the effectiveness of school-based mental health prevention programs and through work on standards used in disseminating evidence-based mental health practices.

Finally, CMHS's Emergency Preparedness Branch is a vital participant in the national health response to natural and man-made disasters. The Branch works closely with the Federal Emergency Management Agency to organize needed services in the field engendered by these events, using an early intervention approach.

Major Policy Developments

The year 1999 was an important one for public mental health in the United States. An Executive order gave Federal employees mental health insurance parity under their employee benefits and opened the way to demonstrating the relative costs and benefits of equity in health care coverage.

That same year, a landmark Supreme Court finding supported the right of people with mental and other disabilities to live in community settings. The *Olmstead* decision (*Olmstead v L.C. by Zimring*, 1999) found that unjustified institutionalization of people with disabilities constitutes discrimination, violating the Americans with Disabilities Act. The responsibility for ensuring equal access falls primarily on States. CMHS took the lead to coordinate activities throughout SAMHSA in response to the *Olmstead* decision. When President Bush announced his New Freedom Commission on Mental Health (Bush, 2002) encompassing the principles of the *Olmstead* decision for the people with mental disabilities, SAMHSA continued to assist States in developing their capacities to provide community-based services. CMHS led an effort to form national and State *Olmstead* Coalitions to Promote Community-Based Care for Persons with Mental Illness. The coalitions sought to identify best prac-

tices and technical resources and to disseminate information on *Olmstead* implementation. Small grants were made available to the States to support State coalitions.

Data and Information

CMHS has a long history of developing projects that address the need for quality data and for creating comparable data standards across the mental health services field. The National Reporting Program (NRP) for Mental Health Statistics, the longest continuous data collection effort in American public health, has been in operation since 1831. It includes biennial enumeration surveys of all specialty mental health organizations in the United States, including managed behavioral health care organizations; periodic targeted client sample surveys of persons served by specialty mental health organizations; special surveys of mental health services in nontraditional settings, such as State prisons, local jails, juvenile justice settings; and self-help activities.

NRP also includes the Mental Health Statistics Improvement Program (MHSIP) to enhance the capacity of the field to collect and use comparable mental health statistics for management and clinical purposes. MHSIP encompasses a set of indicators and measures for a Consumer-Oriented Mental Health Report Card, intended to monitor health care service quality. The Consumer-Oriented Mental Health Report Card also served to stimulate national dialog regarding the development of reliable, comparable, and relevant measures to determine the effectiveness of mental health and substance abuse services. More recently, NRP has undertaken a major effort, *Decision Support 2000+*, to develop a new set of data and information technology standards for the field.

The growing importance of quality improvement, an increasing focus on performance and accountability, and a proposal for Mental Health Performance Partnership Grants to replace the Community Mental Health Services Block Grant Program fueled the movement to develop common performance indicators for the Mental Health Block Grant. The Center collaborated with States to test and develop valid indicators to measure access, capacity, and quality/outcomes for mental health services for adults with serious mental illness and children with severe emotional disturbances. This effort culminated in the development of the Uniform

Reporting System, which in 2002 became part of the Mental Health Block Grant reporting requirement.

The challenge in the data arena was accelerated by the enactment of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), with its goals of increasing access to health insurance; setting a national standard for certain types of insurance provisions, regardless of variations in State requirements; achieving national health data standards; and safeguarding the privacy of health information.

Targeting Emerging Concerns

Mental health services have grown in many ways over the past decade, from efforts to develop a community-based system of care poised to address emerging local issues to initiatives that address special needs in mental health services across the life span. Some of the most important changes, however, are not reflected as clearly in discrete budget lines, although they are critical to a public health approach that looks at causes of illness; addresses disparities; and considers mental health and the use of services as a product of cultural, social, and biological influences.

In the United States, this consideration implies the importance of designing programs that reach out to different racial and ethnic minorities. That is what CMHS has done by creating specially targeted programs, such as the Circles of Care, a multi-agency collaboration that provides grants to programs to develop culturally appropriate systems of mental health care for American Indian/Alaska Native children and families. That also is what CMHS has done to target health disparities among minority and underserved groups. For instance, the Center's HIV/AIDS minority initiative funds 21 community-based organizations and a coordinating center. The diagnosis of HIV/AIDS imposes an enormous emotional, not just physical, toll; this program has provided mental health services for people with HIV/AIDS from vulnerable populations.

The public health approach to mental health that has evolved and the knowledge that has been gained over the past decade also is finding its way into training materials, including tool kits, and education curricula, bringing greater exposure to mental health issues and to the importance of services. CMHS continued to support a Minority Fellowship Program to promote minority leadership in mental

health services, as well as to support an HIV/AIDS Mental Health Provider Education Program.

In its first decade, 1992–2002, the Center advanced the movement for a community-based system of mental health care. The days when serious mental illness meant lifelong institutional care, for the most part, have become history. Throughout its first decade, CMHS maintained its solid commitment to ensuring that adults with serious mental illnesses and children and adolescents with severe emotional disturbances obtain the best available services and supports. This is particularly true for those whose mental health needs are most likely to be overlooked, such as individuals who are homeless or incarcerated in jails or prisons.

Looking to the Future

As CMHS enters its second decade, mental illnesses have been recognized as a major health threat to society. In a study of the global burden of disease conducted by the World Health Organization, the World Bank, and Harvard University, researchers estimate that by the year 2020, depression will become the second leading cause of disability in the world, exceeded only by heart disease (World Health Organization, 1996). The public health model that has guided CMHS in its first decade in the transition to community-based care with a focus on prevention and early intervention has been incorporated into a SAMHSA matrix of priority activities; this matrix will be critical in setting the agenda for the next 10 years. CMHS will continue its mission to serve the mental health needs of all Americans for better outcomes, for lower costs associated with delivery of more efficient services, and for improvements in translating research findings into community-based services.

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